VERIFICATION OF MOBILITY. VISION. OR HEARING DISABILITY Applicant Head of Household name: _ Name of household member who has a mobility, vision or hearing disability: Relationship to Applicant/Head of Household: The Applicant/Head of Household is seeking to be deemed eligible for a dwelling unit that is accessible or can be adapted for use by an individual who has mobility, vision, or hearing disability. A federal law, Section 504 of the Rehabilitation Act, requires that a certain percentage of dwelling units in this development be set aside for households that need such units. A licensed medical doctor must confirm the existence of a qualifying disability of a household member in order for the household to be considered for one of these accessible/adaptable units. In your professional medical opinion: Does the named household member use a wheelchair or is s/he otherwise mobility If yes, is the mobility disability expected to continue for at least 12 months or be of infinite duration? Is the named household member hearing disabled to such a degree that s/he would benefit from a unit for people with a hearing disability (a unit that is equipped with strobe light smoke alarm and doorbell)? ves X no Is the named household member vision disabled to such a degree that s/he would benefit from a unit for people with a vision disability (a unit that is equipped with Braille stove and thermostat markings)? I swear/affirm under penalty of perjury that the information above is accurate and true. Name: (Signature: ST STIBION NY 10 License number: Stamp: MONTEFIORE MEDICAL GROUP 305 East 161st Street Bronx, Nevi York 10451 Tol. (718) 579-2500

Fax (718) 579-2599

Date: May 29, 2017	#2239	18 1
Applicant Head of Household name: _	#ZZUU	8 W W
Phone number:	w" i	15. 36.
Current address:		a -
	New York	
This form should be used by applicants vindicated on the application that they need disabled household member or a household	ed a unit that is accessible or a	daptable for a mobility-
The applicant must complete the first pag- second page. The applicant should give apartment.	ge of this form and have a medi e both pages to the developer	cal doctor complete the at the interview for the
Name of household member who has a #2239	mobility, vision or hearing disa	ability:
Relationship to Applicant: Self-		
Does the named household member disabled?	er use a wheelchair or is s/he oth	erwise mobility
2. If yes, is the mobility disability expe	10	ionths or longer?
3. Is s/he hearing disabled? yes		
4. Is s/he vision disabled? yes _	√ no	
I certify that the above statements are supplying false information may lead to developer and the Department of Housing (HPD) or the New York City Housing Deveny medical doctor and I authorize my description.	the denial of my housing applic p Preservation and Development velopment Corporation (HDC) to	cation. I authorize the of the City of New York verify my eligibility with
Signature of household member who have #2239	mobility, vision, or hearing disate	
May 29, 2017 (date)	(or pariotic or rogar godd	3

From:

07/21/2017 16:26 #902 P.002/002

Jul 20 2017 11:56pm

P002/002

Jul. 19. 2017 [2:12PM -

No. 3613 P. 2/2

525 W. 52ND STREET APTS

HANCOCK APTS 350 W. 124TH STREET, NEW YORK, NY 10027 TEL: (646) 988-8329 PAX: (212) 866-1912

DISABLED VERIFICATION
Dute: 07/17/2017 Log.# 29/1
TO: ATTN' KAKEN L. MORICE, MS RE 2911
MIE, 210 th St Brank, Ny 10467-2401
The ladividual named directly above is an applicant/tenant of a housing program that requires verification of income. We ask that you complete and return this form as soon as possible or fax: (212) 866-1912. The information will be used only in determining eligibility for this particular program. It will not be made available to anyone else. Your prompt response is crucial and greatly appreciated.
If you have any questions, please call our office at tol.: (646) 388-8329
Sincerely,
525 W. SZND STREET APTS
AUTHORIZATION: 1 horolog michael and a state of a stat
INDORMATION BEING REQUESTED: CERTIFICATE OF DISABILITY:
A person who is disabled to the extent of being unable to engage in any substantial gainful activity by reason of any medically
determinable Mobility, Visual, and Mearing impairment which has lasted or can be expected to last for a continuous period of not loss that twolve months.
to my opinion, the above-named person does (does, does not) have a mobility (Mobility, Visual and Hearing
' · · · · · · · · · · · · · · · · · · ·
Evaluator/Diagnostician Name: Karen Morice No
1500: Attending physician suprature: Omorres
7-20-17. 718-547-4940
Tolephane Number
~ 0



VERIFICATION OF MOBILITY, VISION, OR HEARING DISABILITY 2911

Applicant Head of Household name:
Name of household member who has a mobility, vision or hearing disability: DOB:
Relationship to Applicant/Head of Household: Self
The Applicant/Head of Household is seeking to be deemed eligible for a dwelling unit that is accessible or can be adapted for use by an individual who has mobility, vision, or hearing disability. A federal law, Section 504 of the Rehabilitation Act, requires that a certain percentage of dwelling units in this development be set aside for households that need such units. A licensed medical doctor must confirm the existence of a qualifying disability of a household member in order for the household to be considered for one of these accessible/adaptable units.
In your professional medical opinion:
Does the named household member use a wheelchair or is s/he otherwise mobility disabled? yes no
2. If yes, is the mobility disability expected to continue for at least 12 months or be of infinite duration? no
3. Is the named household member hearing disabled to such a degree that s/he would benefit from a unit for people with a hearing disability (a unit that is equipped with strobe light smoke alarm and doorbell)?
yesno
4. Is the named household member vision disabled to such a degree that s/he would benefit from a unit for people with a vision disability (a unit that is equipped with Braille stove and thermostat markings)?
yesno
I swear/affirm under penalty of perjury that the information above is accurate and true.
Name: Karen Morice MD Title: Physician
Signature: Thoras Date: 7-6-(7
Name: Karen Morice MD Title: Physician Signature: 7-6-(7) Address: 111 E. 210th St. Branx, NY 10467 Telephone number: (78-920-4(33)
License number: 247735
Stamp: N/A

Date: 07/11/17 2911
Applicant Head of Household name
Phone number:
Current address:, New York
This form should be used by applicants who have been selected for an interview and who have indicated on the application that they need a unit that is accessible or adaptable for a mobility disabled household member or a household member with vision or hearing disability.
The applicant must complete the first page of this form and have a medical doctor complete the second page. The applicant should give both pages to the developer at the interview for the appartment.
Name of household member who has a mobility, vision or hearing disability: 2911 Relationship to Applicant:
Does the named household member use a wheelchair or is s/he otherwise mobility disabled?
2. If yes, is the mobility disability expected to continue for at least 12 months or longer?
iyes no 3. Is s/he hearing disabled? yesno
4. Is s/he vision disabled?yesno
certify that the above statements are true to the best of my knowledge. I understand that supplying false information may lead to the denial of my housing application. I authorize the developer and the Department of Housing Preservation and Development of the City of New York (HPD) or the New York City Housing Development Corporation (HDC) to verify my eligibility with my medical doctor and I authorize my doctor to provide such verification to the developer and HPD/HDC, on their request.
2911 (or parent or legal guardian if under 18)
D ^7/11/17 (date)

9/6/2017 4:14 PM FROM: Fax 96 st GODVIN MEDICAL PC TO: 2128661912 PAGE: 002 OF 002

525 W. 52ND STREET APTS

HANCOCK APTS 350 W. 124TH STREET, NEW YORK, NY 10027 TEL: (646) 388-8329 FAX: (212) 866-1912

DISABLED VERIFICATION

Date: 8/22/17 Log. # 4382 To: Gradium Medical PC RE: 4382 SS#/Tax I.D., #: Your Just AG 100 The individual named directly above is an applicant/tenant of a housing program that requires verification of We ask that you complete and return this form as soon as possible or fax: (212) 866-1912. The information used only in determining eligibility for this particular program. It will not be made available to anyone else prompt response is crucial and greatly appreciated.	n will be
If you have any questions, please call our office at tel.: (646) 388-8329	
Sincerely, V 5 525 W. 52ND STREET APTS ***********************************	
I heroby authorize release of the information requested on this verification form.	
4382 Fenant Date	
INFORMATION BEING REQUESTED: CERTIFICATE OF DISABILITY:	,
A person who is disabled to the extent of being unable to engage in any substantial gainful activity by reason of any	medically
determinable Mobility, Visual, and Hearing impairment which has lasted or can be expected to last for a continuous	period of
not less that twelve months.	1
Evaluator/Diagnostician Name: West Yark New Yark	No margaret

2.1

VERIFICATION OF MODICITY. VISION, OR REARING DISABILITY
Applicant Head of Household name:
Name of household member who has a mobility, vision or hearing disability: DOB:
Relationship to Applicant/Head of Household: 500
The Applicant/Head of Household is seeking to be deemed eligible for a dwelling unit that is accessible or can be adapted for use by an individual who has mobility, vision, or hearing disability. A federal law, Section 504 of the Rehabilitation Act, requires that a certain percentage of dwelling units in this development be set aside for households that need such units. A licensed medical doctor must confirm the existence of a qualifying disability of a household member in order for the household to be considered for one of these accessible/adaptable units.
In your professional medical opinion:
Does the named household member use a wheelchair or is s/he otherwise mobility disabled?yes no
2. If yes, is the mobility disability expected to continue for at least 12 months or be of infinite duration?yes no
3. Is the named household member hearing disabled to such a degree that s/he would benefit from a unit for people with a hearing disability (a unit that is equipped with strobe light smoke alarm and doorbell)?
4. Is the named household member vision disabled to such a degree that s/he would benefit from a unit for people with a vision disability (a unit that is equipped with Braille stove and thermostat markings)?
I swear/affirm under penalty of perjury that the information above is accurate and true.
Name: Clohlan Rena Title: Rediatrician
Signature: Date: _8/5/2017
Address: 145 W. Su. H (c Telephone number: ()
License number: 243960 212-663-3410
Stamp:
Godwin Medical, PC Dr. Clotilde Pena, MD 145 W 96th Street New York, NY 10025 T: 212-663-3420 F: 347-587-4021

Date: 9/2///	4382	- 1.
Applicant Head of Household name:	-002	4 ¹⁰ 10 10
Phone number:		5 B U
Current address:	x)	
<i>M</i> , No	ew York	
This form should be used by applicants who indicated on the application that they need a disabled household member or a household me	unit that is accessible or	adaptable for a mobility-
The applicant must complete the first page of second page. The applicant should give bo apartment.		
Name of household member who has a mob	ollity, vision or hearing di	sabllity:
Relationship to Applicant: 5-000	***	90 ₂₆ 70 5 5
Does the named household member us disabled?yes no	se a wheelchair or is s/he of	therwise mobility
If yes, is the mobility disability expected	I to continue for at least 12	months or longer?
yes no		a ar
3. Is s/he hearing disabled?yes		
4. Is s/he vision disabled? yes	no	
I certify that the above statements are true supplying false information may lead to the developer and the Department of Housing Pre (HPD) or the New York City Housing Develop my medical doctor and I authorize my doctor HPD/HDC, on their request.	denial of my housing app eservation and Developmen oment Corporation (HDC) to	olication. I authorize the nt of the City of New York o verify my eligibility with
Signature of household member who has a mo 4382	West 26	× /**
$\frac{9/277}{9/2}$ (date)	(or parent or legal qua 4	ardian if under 18) 382
		8 ° 20 °

VERIFICATION OF MOBILITY. VISION. OR HEARING DISABILITY

_	-Applicant Head of Household name: 4/25
_	Name of household member who has a mobility, vision or hearing disability:
	_ 4/23 DOB:
	Relationship to Applicant/Head of Household: Paln Hangement Self
	The Applicant/Head of Household is seeking to be deemed eligible for a dwelling unit that is accessible or can be adapted for use by an individual who has mobility, vision, or hearing disability. A federal law, Section 504 of the Rehabilitation Act, requires that a certain percentage of dwelling units in this development be set aside for households that need such units. A licensed medical doctor must confirm the existence of a qualifying disability of a household member in order for the household to be considered for one of these accessible/adaptable units.
	In your professional medical opinion:
	Does the named household member use a wheelchair or is s/he otherwise mobility disabled? yes no
	2. If yes, is the mobility disability expected to continue for at least 12 months or be of infinite duration? yes no
	3. Is the named household member hearing disabled to such a degree that s/he would benefit from a unit for people with a hearing disability (a unit that is equipped with strobe light smoke alarm and doorbell)?
	yes <u>×</u> no
	4. Is the named household member vision disabled to such a degree that s/he would benefit from a unit for people with a vision disability (a unit that is equipped with Braille stove and thermostat markings)?
	yesno
	I swear/affirm under penalty of perjury that the information above is accurate and true.
	Name: Jessica Au Title: M.D.
	Signature: Date:
	Address: 369 East 149th St 9th TL Telephone number: ()
	License number: 26 978 / 718-401 - 11/1
	Stamp:

4723

Scan on 8/2/2017 by Rebecca Gonzalez [REG2017] of Verification of Mobility, Vision, Hearing Form- C

Printed on 8/2/2017 12:42 PM

Page 1 of 1

4723

Scan on 8/2/2017 by Peter Alphonso of Verification of Mobility, Vision, and Hearing Form

	10		
	VERIFICATION OF MOBILITY VISION OF HEARING DISABILITY		
Applic	cant Head of Household name: 4/23		(R)
Name	of household member who has a mobility, vision or hearing disability: 4723 DOB: 136	50	
Relati	ionship to Applicant/Head of Household: 10/0 the 2	**	
A fede	Applicant/Head of Household is seeking to be deemed eligible for a dwelling unit the sible or can be adapted for use by an individual who has mobility, vision, or hearing disasteral law, Section 504 of the Rehabilitation Act, requires that a certain percentage of dwellin this development be set aside for households that need such units. A licensed more must confirm the existence of a qualifying disability of a household member in order for a household member in order for the considered for one of these accessible/adaptable units.	elling edical	E Fig.
In you	ur professional medical opinion:		
1. disabi	Does the named household member use a wheelchair or is s/he otherwise mobility led? no		(17/)
2. durati			
	Is the named household member hearing disabled to such a degree that s/he would be a unit for people with a hearing disability (a unit that is equipped with strobe light smoke doorbell)?	aiaith	¥
4. from them	Is the named household member vision disabled to such a degree that she would ber a unit for people with a vision disability (a unit that is equipped with Braille stove and nostat markings)?	iefit.	
	yesno	30	
swe	ear/affirm under penalty of perjury that the information above is accurate and true.	See	
	e: July Tung Title: MD.	9	
	ature:		15
	ress: 505 E 70 Et Telephone number: ()12-70	16-15	828
Licer	nse number: 216747		
Stan	Dept. of Medicine	06	
	New York, NY 10038	80	

Date: 8/1/2017 4723
Applicant Head of Household name:
Phone number:
Current address: Bronk New York
This form should be used by applicants who have been selected for an interview and who have indicated on the application that they need a unit that is accessible or adaptable for a mobility disabled household member or a household member with vision or hearing disability.
The applicant must complete the first page of this form and have a medical doctor complete the second page. The applicant should give both pages to the developer at the interview for the apartment.
4723 Control of household member who has a mobility, vision or hearing disability:
Relationship to Applicant:Self
Does the named household member use a wheelchair or is s/he otherwise mobility disabled? no
2. If yes, is the mobility disability expected to continue for at least 12 months or longer? yes no
3. Is s/he hearing disabled? yesno
1. Is s/he vision disabled?yes _1/_ no
certify that the above statements are true to the best of my knowledge. I understand that supplying false information may lead to the denial of my housing application. I authorize the developer and the Department of Housing Preservation and Development of the City of New York (HPD) or the New York City Housing Development Corporation (HDC) to verify my eligibility with my medical doctor and I authorize my doctor to provide such verification to the developer and HPD/HDC, on their request.
7722 who has a mobility, vision, or hearing disability:
4723 (or parent or legal guardian if under 18)
8/1/2017 (date)

9/1	5/2017 2:39 PM FROM: Fax	GROUPO MEDICO	DOMINICANO TO:	12128661912	PAGE: 002 OF 0	03
525 W. 52	ND STREET A	PTS			19	26
AND REPORT OF THE PARTY OF THE	rs 350 W. 124 TH STREET		C, NY 10027	TEL: (646) 388-	8329 FAX: (212)	PHYSIAN PROCESSING STATES
		disabled v	erification	ł		•
Dele: AIRIT	7	<u>:</u> :	Log. # 586	5804		
To: Gladolas	1 185 street K. 14 10033 -	- ig-mount	RE: SS#/Tax I.D. #:	-		
We ask that you used only in dete	oned directly above is an a complete and return this fi conining eligibility for this is crocial and greatly appre	brim as soon as s particular pro	possible or far	c: (212) 866-19	12. The infor	mation will be
If you have any	questions, please call our	office at tel.:	(646) 388-8329			
Sincorely, 525 W. 52ND ST	TO THE ADTO	Ē.				
AUTHORIZAT	******	***	t********	፟ ፟ውቀ <i>ት ት</i> ሉ ቁ ት ቅ ቅ		
I hereby authoriz	e release of the information	on requested o	a this verificati	on form.		
½ 580			_9	112/17		
Signature of App	I KORD Lenant		Date	***************************************		
	BRING REQUESTED: OF DISABILITY:	1				
A person who is di	isabled to the extent of being	umble to engi	ge in any substa	otial gainful acti	ivity by reason o	fany medically
determinable Meb	illy, Visual, and Hearing Im	pakment which	has lested or ca	a be expected to	last for a conti	mous period of
not less that twelve	JO	04				
in my opinion, the	above-named perso: ined abovo.	(does) d	seved (lon zeo		(Mobility) Vis	oal and Hearing
Evaluator Diagno	silician Name: Martha M	, Valdivia, MI) R	1		
Tide	NP #1	083646970	Signature:	Lede	u i	cu
Ç	distr .		(212)	1 928-3	900	•
Date	7 7		To lophous Num	The state of the s	- Lander Control of the Control of t	
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	'	8		į	å	ANT HOUSTAG

CENTRO

629 WEST 185H - KEET NEW YORK, NY 10033

Stamp:

VERIFICATION OF MOBILITY, VISION, OR HEARING DISABILITY Applicant Head of Household name: __ Name of household member who has a mobility, vision or hearing disability: DOB: Relationship to Applicant/Head of Household: mothey The Applicant/Head of Household is seeking to be deemed eligible for a dwelling unit that is accessible or can be adapted for use by an individual who has mobility, vision, or hearing disability. A federal law, Section 504 of the Rehabilitation Act, requires that a certain percentage of dwelling units in this development be set aside for households that need such units. A licensed medical doctor must confirm the existence of a qualifying disability of a household member in order for the household to be considered for one of these accessible/adaptable units. In your professional medical opinion: Does the named household member use a wheelchair or is s/he otherwise mobility disabled? ves no If yes, is the mobility disability expected to continue for at least 12 months or be of infinite 2. duration? is the named household member hearing disabled to such a degree that s/he would benefit from a unit for people with a hearing disability (a unit that is equipped with strobe light smoke alarm and doorbell)? Is the named household member vision disabled to such a degree that s/he would benefit from a unit for people with a vision disability (a unit that is equipped with Braille stove and thermostat markings)? I swear/affirm under penalty of perjury that the information above is accurate and true. Gladstone L. Guniss Lic. #002809-1 NPI #185153247 Signature: Telephone number: (Address: 002801 License number:

CANO

Date: 8/10/17 5804
Applicant Head of Household name:
Phone number:
Current address:
This form should be used by applicants who have been solders and adaptable for a mobility indicated on the application that they need a unit that is accessible or adaptable for a mobility indicated on the application that they need a unit that is accessible or adaptable for a mobility indicated on the application that they need a unit that is accessible or adaptable for a mobility.
indicated on the application of a household member with vision of the disabled household member or a household member with vision of the disabled household member or a household member with vision of the disabled household member or a household member with vision of the disabled household member or a household member with vision of the disabled household member or a household member with vision of the disabled household member or a household member with vision of the disabled household member or a household member with vision of the disabled household member or a household member with vision of the disabled household member or a household member with vision of the disabled household member or a household member with vision of the disabled household member or a household member with vision of the disabled household member or a household member with vision of the disabled household member or a household member with vision of the disabled household member with vision with vision of the disabled household member with vision
apartment. Name of household member who has a mobility, vision or hearing disability:
58N/ 3004
Relationship to Applicant:
Does the pamed nouseries to disabled?
yes no Is s/he hearing disabled? yes no
4. Is s/he vision disabled?yes the best of my knowledge. I understand that
I certify that the above statements are true to the best of my knowledge. I understand that the above statements are true to the best of my knowledge. I understand the certify that the above statements are true to the best of my knowledge. I understand the supplying false information may lead to the denial of my housing application. I authorize the supplying false information may lead to the denial of my housing application. I authorize the supplying false information may lead to the denial of my housing application. I authorize the supplying false information may lead to the denial of my housing application. I authorize the supplying false information may lead to the denial of my housing application. I authorize the supplying false information may lead to the denial of my housing application. I authorize the supplying false information may lead to the denial of my housing application. I authorize the supplying false information may lead to the denial of my housing application. I authorize the supplying false information may lead to the denial of my housing application. I authorize the supplying false information may lead to the denial of my housing application. I authorize the supplying false information may lead to the denial of my housing application. I authorize the supplying false information may lead to the denial of my housing application. I authorize the supplying false information may lead to the denial of my housing application. I authorize the supplying false information may lead to the denial of my housing application. I authorize the supplying false information may lead to the denial of my housing application. I authorize the supplying false information may lead to the denial of my housing application. I authorize the supplying false information may lead to the denial of my housing application. I authorize the supplying false information may lead to the denial of my housing application in the denial of my housing application in the denial of my housing application in the denial of my housing applic
Madical docor
HPD/HDC, on their request. Signature of household member who has a mobility, vision, or hearing disability: (or parent or legal guardian if under 18)
110/17 (date)